CONFIDENTIAL

Title:	Affordable Care	**Effective Date:**	2018-01-18	**Policy #:**	FS-103
Applies to:	☐ Gifford Health Care ☒ Gifford Medical Center ☐ Gifford Retirement Community				
Division:	☐ Primary Care ☒ Hospital ☒ Surgical ☒ Operations ☒ Administrative Svcs.				
Contact:	Director of Patient Financial Services				

Purpose/Policy Statement: Gifford Medical Center will offer Affordable Care if an individual's or family's income is within the specified parameters, their assets or lack of assets meet established standards, and all other means of reimbursement have been exhausted. These standards must be clearly demonstrated and documented. Availability of Affordable Care will be consistent with Gifford Medical Center's ability to provide such care as determined by Administration and the Board of Directors.

Gifford Medical Center recognizes that some patients do not have the ability to pay for their medical care. Gifford Medical Center is committed to extending Affordable Care to individuals and families with limited financial resources. Individuals and families who have received services from Gifford Medical Center, which have resulted in outstanding financial obligations to the hospital, may apply for assistance through this program. Applications will be processed and approval will be determined based on specified criteria. If approved, their obligation to Gifford Medical Center will be reduced in full or in part. Approval is based on the criteria set forth in this document and the ability of the patient/guarantor to demonstrate the need and limited resources. Gifford Medical Center will not discriminate in the determination of Affordable Care eligibility on the basis of race, color, creed, sex, age, or handicap.

All patients and guarantors who request or require Affordable Care should be referred to the Affordable Care Coordinator in the Patient Financial Services Department of Gifford Medical Center.

Affordable Care will be applied to non-elective services that are medically necessary. Medically necessary services are defined as services that are reasonable and necessary for the diagnosis and treatment of an illness or injury. Non-medically necessary services are defined as cosmetic, patient convenience, or non-urgent services that would not put functional capacity or life at risk if not rendered. Further, experimental treatments, treatments that do not improve the patient's condition and services that do not functionally prevent further degradation of the condition shall not be covered under this policy.

Affordable Care may be provided to patients who have not filed a formal application. These allowances can be authorized, by Administration, based on extenuating circumstances. This provision is not intended to be used as an alternative to the application process, but to provide the necessary administrative flexibility in certain situations. Additionally, Gifford Medical Center may use its discretion to administratively approve or deny Affordable Care, based on circumstances relative to the patient or guarantor's ability to make payment.

PROCEDURE:

1. The patient shall be referred to the Affordable Care Coordinator if they request or indicate a need for Affordable Care.
2. All applicants will be counseled by the Affordable Care Coordinator as needed and as appropriate. Availability of assistance from other sources will be investigated. The Affordable Care Program will be considered to be secondary to all other sources of reimbursement. All other means of reimbursement must be exhausted and documented as such. Pending third party liability claims are not eligible for the Affordable Care Program until written confirmation is received denying the claim and all appeals have been adjudicated. This includes Worker's Compensation, Auto Accidents, Torte Feasors, etc.

3. Upon determination that all other sources of assistance have been exhausted; the patient must complete an Affordable Care Application (Attachment A). This completed form must be submitted to the Affordable Care Coordinator along with documentation of current income and proof of denial from other sources of assistance. The application must be complete and accurate.

   A. Household size and income. Income may be documented by:
      1. Copy of most recent tax form
      2. Copy of most recent income statement(s)
      3. Copy of most recent pay stub(s)
      4. Signed statement of income from employer(s)
      5. Copies of benefit statements; i.e. Social Security, A.F.D.C., Worker's Compensation, Pensions, etc.
      6. Other records as required

   B. Full names and ages of patients concerned

   C. Assets and liabilities

   D. Required demographic information; i.e. address, telephone number, social security number, etc.

   E. Guarantor's dated signature

4. Income includes salaries, wages and tips, earned interest, dividends, pensions, alimony, or any source of income recognized by the Internal Revenue Service or Federal Government.

5. Upon receipt of the completed form and required documentation, the Affordable Care Coordinator will organize and evaluate the applications and the related bills.

6. The Affordable Care Coordinator will perform the review of the applications a minimum of once a month. The application and documentation will be utilized to determine eligibility. Eligibility is based on the following:

   A. Affordable Care will only be extended to patients who reside within the service area of Gifford Medical Center (Attachment B). Applicants who are not citizens of the United States will not be considered for this program. Patients who live outside the service area may be considered for the program if the services rendered were emergent or unavailable in their residential area.

   B. An applicant's total household income must fall within the guidelines established by Gifford Medical Center (Attachment C). These guidelines are based on the C.S.A. Income Poverty Guidelines. These guidelines will be updated annually. The guidelines are set up with a prorated scale of assistance based on income.

   C. Ownership and assets will be considered for each application for assistance totaling over $25,000 or for services rendered to SNF or ICF level patients in the Nursing Home or Swing Bed unit. Ability to satisfy the obligation through these assets will be determined. Assets such as Bank Accounts, Real Estate, Stocks, Bonds and others will be considered to be available resources

   D. Household size and dependent status will be based on Federal Standards. Full time students who have been claimed as dependents on their parent's tax return will not be considered to be independents

   E. The patient was not directly reimbursed for the services concerned, by any other source.

   F. The outstanding balance(s) are not the result of a penalty assessed for failure to comply with the provisions set forth in the insured's insurance contract.

7. Based on the above referenced eligibility requirements, the Affordable Care Coordinator will approve or deny each application. The Affordable Care Coordinator may approve all adjustments for Affordable Care under $10,000.00 for a given applicant. For adjustments greater than $10,000.00 per applicant, the Affordable Care Coordinator must present these recommended adjustments and their related applications to the Vice President of Finance.
8. Once the determination has been made and all required signatures/approvals have been received, a list of approved adjustments will be given to the Cashier in the Patient Financial Services Department. The Cashier will post the appropriate write-off transactions on the appropriate patient accounts. Written verification of approval and denial will be sent to the applicants within two (2) weeks of determination. The Affordable Care Coordinator is responsible for generating this notification.
9. All qualified services that are rendered to a patient previously approved for Affordable Care, are covered under the previous approval, if these additional services were rendered within one hundred and eighty (180) days of the approval. All previously mentioned eligibility requirements are required to be met for services provided within this window of approval. A new application and updated documentation will be required after this time period window has expired or if their financial situation has significantly changed.
10. The Patient Financial Services Manager and/or the Affordable Care Manager are required to produce necessary statistics and reports.
11. Other considerations:

    A. The application and approval can occur before, during, or after the treatment so long as the account has not been written off to bad debt prior to receipt of completed application and necessary documentation. Accounts sent to bad debt after required information has been received can be returned from collections for processing without penalty to the applicant. Gifford Medical Center encourages the application process to begin as early as possible.

    B. Patient receiving benefits from certain programs through Medicaid, may have already had comparable income and asset tests completed through that program. Accordingly, their approval can be expedited with proof of coverage under those programs.

    C. Balances after insurance, not inclusive of balances designated as co-payment amounts or penalties for non-compliance with policy coverage requirements, are not eligible for Affordable Care.

    D. GMC recognizes decisions made by the following assistance programs without requesting copies of applications. All applicable co-pays or other patient responsibility amounts should be requested in accordance with requirements of such programs.

        - Gifford Health Care
        - Soares Ocular Surgery, P.C.

Attachment B.

Gifford Medical Center Service Area

Barnard	Bethel	Braintree
Brookfield	Chelsea	Granville
Hancock	Northfield	Pittsfield
Randolph	Rochester	Roxbury
Royalton	Sharon	Stockbridge
Tunbridge	Vershire	Williamstown

Attachment C.
Gifford Medical Center
Income Guidelines
Gifford Affordable Care Program

Eligibility is determined by measuring family income against the Income Poverty Guidelines established by the Department of Health and Human Services (DHHS).

FAMILY SIZE	INCOME	EQUAL TO OR	LESS THAN
	225%	**267%**	**300%**
1	27,135	32,200	36,180
2	36,540	43,361	48,720
3	45,945	54,521	61,260
4	55,350	65,682	73,800
5	64,755	76,843	86,340
6	74,160	88,003	98,880
7	83,565	99,164	111,420
8	92,970	110,324	123,960
	FREE CARE	**80% DISCOUNTED CARE**	**70% DISCOUNTED CARE**

As defined by the IRS, eligible patients cannot be charged more for emergency or other medically necessary care than amounts generally billed to individuals who have insurance coverage. The average generally billed (AGB) to patients is calculated using the "Look-Back method"; actual claims paid to the organization by Medicare only or claims paid to the organization by Medicare together with all private health insurers, including any associated portions of these claims paid or owed by beneficiaries.

Key Words: affordable, patients, guarantors, application

All Staff (non-providers): A policy is intended to clarify expected practice and commit the organization/staff to a specific course of action. Any temporary requests or decisions to modify an expected course of action as outlined in a policy must be approved by Senior Management or the Administrator-on-Call.

Providers: Not all patient situations will fit the policy as written. Patient care is individualized based on professional judgment and a patient's condition may require a change in the care provided. Deviation from the written, adopted policy should be clearly documented in the patient's medical record along with the rationale for such deviation.

Standard or Statute:	☒ N/A ☐ CAH Standard ☐ NH Standard ☐ FQHC ☐ Labor Statute ☐ VT State Statute ☐ Compliance/HIPAA ☐ Other	**Standard or Statute Details:**	